Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Rosewood Care Center of Rockford
Docket No. A-12-35
Decision No. 2466
June 19, 2012

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Rosewood Care Center of Rockford (Rosewood), an Illinois skilled nursing facility (SNF), appeals the October 4, 2011 decision by Administrative Law Judge (ALJ) Steven T. Kessel, *Rosewood Care Center of Rockford*, DAB CR2440 (2011) (ALJ Decision). The ALJ upheld a determination by the Centers for Medicare & Medicaid Services (CMS) that Rosewood was not in substantial compliance with Medicare participation requirements from August 6 through October 27, 2010. The ALJ also sustained CMS's determination that Rosewood's noncompliance put residents in "immediate jeopardy" from August 6 through August 12, 2010. In addition, the ALJ upheld the remedies imposed by CMS for the noncompliance.

For the reasons outlined below, we affirm the ALJ Decision in its entirety.

Legal Background

To participate in Medicare, a SNF must at all times be in "substantial compliance" with the requirements in 42 C.F.R. Part 483. 42 C.F.R. § 483.1. State health agencies conduct on-site surveys to verify compliance with those requirements. A survey's noncompliance findings are reported in a Statement of Deficiencies (SOD). "Noncompliance" means any deficiency that causes a facility to not be in "substantial compliance." 42 C.F.R. § 488.301.

CMS may impose enforcement "remedies" – including civil money penalties (CMPs) and a denial of payment for new Medicare admissions (DPNA) – for any days on which the SNF is not in substantial compliance with one or more Medicare participation requirements. 42 C.F.R. § 488.402(b), (c). In choosing an appropriate remedy, CMS considers the "seriousness" of the SNF's noncompliance and may consider other factors specified in the regulations. *Id.* § 488.404(a), (c). "Seriousness" is a function of: (1) "severity" – that is, whether the noncompliance has created a "potential" for "more than minimal" harm, resulted in "actual harm," or placed residents in "immediate jeopardy" (the latter circumstance is the highest degree of severity); and (2) "scope" –

whether the noncompliance is "isolated," constitutes a "pattern," or is "widespread." *Id.* § 488.404(b); State Operations Manual, CMS Pub. 100-07, Appendix P – *Survey Protocol for Long Term Care Facilities*, sec. IV ("Deficiency Categorization").[1]

When CMS imposes a per-day CMP for noncompliance at the immediate jeopardy level of severity, it must set the CMP amount within the "upper range" of $3,050 to $10,000 per day. 42 C.F.R. §§ 488.408(d)(3)(ii), 488.438(a)(1)(i). A per-day CMP for noncompliance below the immediate jeopardy level must be set within the "lower range" of $50 to $3,000 per day. *Id.* § 488.408(d)(1)(iii), 488.438(a)(1)(ii).

Case Background

On July 28, 2010, the Illinois Department of Public Health (IDPH) completed a survey of Rosewood. *See* P. Ex. 1. Based on that survey (July survey), IDPH issued two noncompliance citations that are not at issue in this appeal. *Id.*

On August 5, 2010, IDPH notified Rosewood that, in view of the July survey findings, a "discretionary" DPNA would take effect on September 27, 2011 in the event Rosewood was not, by that date, in substantial compliance with all Medicare participation requirements.[2] *See* CMS Ex. 4, at 2.

On August 13, 2010, IDPH began another survey of Rosewood in response to a complaint. During that "complaint survey," IDPH reviewed an incident in which Resident 5, a diabetic, did not receive his prescribed insulin because Rosewood's nursing staff did not transfer information from a June 2010 Medication Administration Record (MAR) to the resident's July 2010 MAR. *See* CMS Ex. 7, at 1 (showing entrance date of survey led by team leader Patricia Frye regarding complaint number 1013220); CMS Ex. 11 (records relating to Resident 5); CMS Ex. 18 (Frye Decl.), ¶¶ 3-5.

On August 23, 2010, IDPH initiated another complaint survey. That survey's primary purpose was to investigate Rosewood's admitted failure to provide prescribed medication to Resident 2 on August 6, 2010, the date she was admitted to Rosewood. CMS Ex. 7, at 2 (showing entrance date of survey led by Robin Conley regarding complaint number 1013341); CMS Ex. 9 (records relating to Resident 2); CMS Ex. 17 (Conley Decl.), ¶¶ 3-6.

[1] Appendix P of the SOM is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_p_ltcf.pdf.

[2] It appears that CMS imposed the DPNA pursuant to 42 C.F.R. § 488.417(a), which authorizes the imposition of an "optional" DPNA for any days on which the SNF is not in substantial compliance with Medicare participation requirements.

The two complaint surveys proceeded concurrently after August 23, 2010 and were completed on September 2, 2010. CMS Ex. 7, at 11. As the ALJ did, we refer to the complaint surveys collectively as the September survey.

Based on the September survey, IDPH cited Rosewood for noncompliance with the Medicare requirements in sections 483.20(k)(3)(i), 483.25(g)(2), 483.25(m)(2), and 483.75(l)(1). CMS Ex. 1. The previously mentioned circumstances involving Resident 5 and Resident 2 were the grounds for IDPH's determination of noncompliance with section 483.25(m)(2), which requires a SNF to "ensure" that residents are "free of any significant medication errors." *Id.* at 13-22. IDPH also determined that the noncompliance affecting Resident 2 was at the immediate jeopardy-level of severity beginning on August 6, 2010, and that Rosewood did not abate the immediate jeopardy until August 13, 2010. *Id.* at 13-14.

On September 7, 2010, IDPH notified Rosewood that it was recommending the following additional remedies in view of the September survey findings: (1) a $3,050 per-day CMP for the period of immediate jeopardy-level noncompliance, which ended on August 13, 2010; and (2) a $200 per-day CMP from August 13, 2010 until Rosewood achieved substantial compliance with all requirements. CMS Ex. 3, at 2.

On October 27, 2010, IDPH completed a "revisit" survey (October survey) during which it determined that Rosewood was back in substantial compliance with all but one requirement, section 483.25(m)(2). CMS Ex. 4, at 2; CMS Ex. 14, at 2, 4. As evidence of Rosewood's continuing noncompliance with that regulation, IDPH pointed to a medication error that allegedly occurred on October 19, 2010. CMS Ex. 2.

IDPH performed another revisit survey in November 2010 and found that Rosewood was back in substantial compliance with section 483.25(m)(2) on October 28, 2010. CMS Ex. 4, at 2.

In January 2011, CMS notified Rosewood that the following remedies had accrued and would be imposed based on the noncompliance found during the July, September, and October surveys: (1) a $3,050 per-day CMP from August 6 through August 12, 2010; (2) a $200 per-day CMP from August 13 through October 27, 2010; and (3) a DPNA from September 27 through October 27, 2010. CMS Ex. 4, at 2-3.

Rosewood appealed these remedies to the ALJ, contesting most of the underlying deficiency citations. Rosewood later waived its right to an in-person hearing and consented to a decision by the ALJ based on the parties' written submissions and documentary evidence. Rosewood conceded that it was noncompliant with section

483.25(m)(2) at the immediate jeopardy level on August 6, 2010 but contended that it had abated the immediate jeopardy – that is, reduced the severity of its noncompliance with section 483.25(m)(2) below the immediate jeopardy level – by August 7, 2010. Rosewood also contended that it was back in substantial compliance with section 483.25(m)(2) by August 13, 2010.

The ALJ rejected those contentions. He found insufficient evidence that Rosewood abated the immediate jeopardy earlier than August 13, 2010. ALJ Decision at 6. He further found that Rosewood remained noncompliant (below the immediate jeopardy-level) with section 483.25(m)(2) on August 13, 2010 and did not attain substantial compliance with that requirement until October 28, 2010. *Id.* at 3. In addition, the ALJ concluded that Rosewood was noncompliant with sections 483.20(k)(3)(i), 483.25(g)(2), and 483.75(l)(1) during the September survey. *Id.* at 8-12. Finally, the ALJ held that CMS had lawfully imposed the CMPs and DPNA, and that the CMP amounts were reasonable. *Id.* at 12-13.

Standard of Review

The Board's standard of review concerning a disputed finding of fact is whether the finding is supported by substantial evidence on the record as a whole. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs*, http://www.hhs.gov/dab/divisions/appellate/guidelines/index.html. The Board's standard of review concerning a disputed conclusion of law is whether the conclusion is erroneous. *Id.*

Substantial evidence means "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971), *quoting Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938). Under the substantial evidence standard, the Board does not re-weigh the evidence or overturn an ALJ's "choice between two fairly conflicting views" of the evidence; instead, the Board determines whether the contested finding could have been made by a reasonable fact-finder "tak[ing] into account whatever in the record fairly detracts from the weight of the evidence" that the ALJ relied upon. *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 488 (1951); *see also Allentown Mack Sales and Service, Inc. v. NLRB*, 522 U.S. 359, 377 (1998); *Golden Living Center – Frankfort*, DAB No. 2296, at 9-10 (2009). In addition, "[t]he Board defers to an administrative law judge's findings on credibility of witness testimony unless there are compelling reasons not to do so." *Columbus Nursing and Rehabilitation Center*, DAB No. 2398, at 4 (2011).

Discussion

In this appeal, Rosewood raises several issues, most of which it raised before the ALJ. We first address the issue regarding the duration of the immediate jeopardy noncompliance. We then address each of the other noncompliance findings appealed by Rosewood.

1. *CMS's determination that Rosewood did not abate the immediate jeopardy until August 13, 2010 was not clearly erroneous.*

As we noted above, CMS's immediate jeopardy determination concerned Resident 2, about whom the ALJ found the following facts:

> On [August 6, 2010], at 3:30 in the afternoon, Petitioner admitted . . . [Resident 2]. This resident's medical problems included a history of malignant hypertension, in other words, potentially lethal high blood pressure. The resident came to the facility with prescriptions for several anti-hypertensive medications. Notwithstanding, Petitioner's staff failed to administer these medications to the resident on August 6. Petitioner did not have the necessary medications on hand. At 8:30 on the evening of August 6 – five hours after the resident was admitted – Petitioner's staff asked a pharmacy to rush the needed medications to Petitioner. The staff anticipated administering the medications to [Resident 2] at some point during the next nursing shift, or early on the morning of August 7, 2010. The record does not show that the resident received the necessary medications at Petitioner's facility, either on the evening of August 6 or during the early morning hours of August 7, 2010. Early on the morning of August 7, 2010, [Resident 2] complained of a stomach ache and headache. Her blood pressure was recorded at 210/100. The resident was brought by ambulance to a hospital emergency room at about 3:50 on the morning of August 7. The emergency room physician concluded that [Resident 2] suffered from . . . [p]ulmonary edema likely secondary to hypertensive emergency. . . . The resident remained in the hospital, in intensive care, for six days before being discharged.

ALJ Decision at 3-4 (citations omitted). Based on these facts, the ALJ further found that Rosewood: (1) "endangered the life of [Resident 2] by failing to give her blood pressure medications that were necessary to treat her malignant hypertension"; (2) "failed to comprehend the extreme danger that their inaction posed for [Resident 2]"; and (3) "had no mechanism in place for assessing the urgent medication needs of newly admitted residents, and no mechanism for assuring that newly admitted residents would receive necessary medication." *Id.* at 4.

As it did before the ALJ, Rosewood concedes that it was noncompliant with section 483.25(m)(2) at the immediate jeopardy level on August 6, 2010. Request for Review (RR) at 4. However, it maintains that it abated the immediate jeopardy on August 7, 2010, and not August 13, 2010 (as CMS and the ALJ determined). RR at 4-5.

The regulations require that "CMS's determination as to the level of noncompliance of [a skilled nursing facility] must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c). Under the "clearly erroneous" standard, CMS's immediate jeopardy determination – which is a determination about the "level of noncompliance" – is presumed to be correct, and Rosewood has a heavy burden to overturn it. *Barbourville Nursing Home*, DAB No. 1962, at 11 (2005), *aff'd, Barbourville Nursing Home v. U.S. Dep't of Health & Human Servs.*, 174 F. App'x 932 (6th Cir. 2006). Furthermore, "[a] determination by CMS that a [facility's] ongoing [noncompliance] remains at the level of immediate jeopardy during a given period [also] constitutes a determination about the 'level of noncompliance'" and is thus subject to the clearly erroneous standard of review. *Brian Center Health and Rehabilitation/Goldsboro*, DAB No. 2336, at 7-8 (2010).

CMS's determination concerning the duration of the immediate jeopardy was not clearly erroneous, as the ALJ implicitly found.[3] In support of its claim that it abated the immediate jeopardy by August 7, Rosewood points to a written "removal plan" (the contents of which were reproduced in the SOD for the September survey). CMS Ex. 12, at 1; CMS Ex. 1, at 18-19. The removal plan lists, in chronological fashion, various corrective actions allegedly taken by Rosewood between August 6 and August 13, 2010 in response to the medication error that resulted in Resident 2's hospitalization. *Id.* at 2-4.

According to the removal plan, on August 7 (a Saturday), Rosewood's Director of Nursing (DON): (1) informed Resident 2's representative of the medication error and of the "immediate measures to address the concern"; (2) discussed the incident with a "Corporate Consulting Nurse"; (3) "arrived at the facility to begin investigating what occurred and determined that all medications need[ed] to be secured as soon as possible upon admission and/or used from the convenience box as necessary"; (4) "began inservicing the nurses"; and (5) "assured all new residents['] medications were accounted for and properly administered from the current and previous day." *Id.* at 2. Also on August 7, Rosewood's Administrator began his investigation and discussed "immediate follow-up actions" (which the plan did not further specify) with a Regional Operations Manager. *Id.* Finally, Resident 2's "admitting nurse . . . was suspended pending the outcome of the investigation." *Id.*

[3] Although the ALJ did not say that he was reviewing CMS's immediate jeopardy determination under a clearly erroneous standard, it is clear that he placed the burden on Rosewood to demonstrate that it abated the immediate jeopardy prior to the abatement date determined by CMS. *See* ALJ Decision at 5 (stating it was Rosewood's "duty to prove why its corrective actions abated immediate jeopardy").

The Board has held that immediate jeopardy is abated "only when the facility has implemented necessary corrective measures so that there is no longer any likelihood of serious harm." *Pinehurst Healthcare & Rehabilitation Center*, DAB No. 2246, at 15 (2009). Given the nature of the noncompliance affecting Resident 2 (described by the ALJ), CMS could reasonably determine that a likelihood of serious harm – and thus a state of immediate jeopardy – continued to exist at Rosewood until its staff: (1) "comprehend[ed] the extreme danger that [its] inaction posed" for Resident 2 and other similarly situated residents; (2) instituted a "mechanism for assessing the urgent medication needs of newly admitted residents"; and (3) instituted a "mechanism for assuring that newly admitted residents would receive necessary medication." ALJ Decision at 4.

In substance, the ALJ found, and we concur, that these circumstances for removing the immediate jeopardy did not exist on August 7, 2010.[4] ALJ Decision at 6-7. Although Rosewood's DON and Administrator may have immediately "comprehended" the "extreme danger" resulting from the noncompliance, it is unclear whether other employees did as well. As the ALJ accurately noted (ALJ Decision at 7), the removal plan indicates that the DON merely "began" to "inservice" – re-educate or retrain the staff – on August 7. The plan does not specify what the staff was told or indicate that all nurses with responsibility for obtaining and administering medication were inserviced that day.

Also unclear is whether Rosewood had temporary or permanent safeguards in place by August 7 to ensure that newly admitted residents were timely and adequately assessed for their medication needs and actually received their necessary medications. Rosewood maintains that it had such safeguards in place by August 7. *See* RR at 7-8. Those safeguards, Rosewood says, involved the "use of a licensed pharmacy to deliver drugs four times a day and keeping a convenience box for medicines at the facility." *Id.* We see no evidence, however, that those safeguards were implemented by August 7. The removal plan states merely that the DON "determined" on August 7 that all necessary medications should be obtained from outside sources or the facility's "convenience box." CMS Ex. 12, at 2. We agree with the ALJ that "determining that a newly admitted resident's medications needed to be secured as soon as possible is not proof that this determination, even after it was communicated to the staff, was immediately and effectively implemented by the staff." ALJ Decision at 6. The removal plan also indicates that unspecified "follow-up" measures were still being designed or implemented on August 10. CMS Ex. 12, at 3 (stating that a "Corporate RN Consultant" was

[4] It is reasonable to think that Rosewood needed a reasonably full and accurate understanding of the circumstances that led to the medication error before it could formulate an effective abatement plan. Acquiring that understanding was an apparent purpose of the internal investigations initiated by Rosewood's Administrator and DON on August 7. We see no evidence that those investigations were complete or reasonably complete by August 7.

"continuing to assist" with "follow-up measures" on that date). In addition, the plan indicates that the staff was still being trained or re-trained on August 12 about relevant pharmacy and medication policies, including policies on "medication deliveries." CMS Ex. 12, at 3-4. CMS could reasonably infer from this information that Rosewood did not implement (or adequately implement) the DON's "determination" until well after August 7.

Rosewood suggests that we should accept its position on this issue because IDPH did not issue a clear determination in the SOD about when the immediate jeopardy was abated and may have "confused the concept of abating the immediate jeopardy with" its plan for coming back into substantial compliance. RR at 13-14. We agree with the ALJ that there is no ambiguity in the SOD; it plainly states that the "Immediate Jeopardy was removed on August 13, 2010[.]" CMS Ex. 1, at 14. Moreover, IDPH's September 7, 2010 notice letter stated that IDPH had recommended an upper-range CMP for the period August 6 through August 12, 2010. CMS Ex. 3, at 2. Because an upper-range CMP is reserved for noncompliance at the immediate jeopardy-level of severity, the recommendation for an upper-range CMP for the period through August 12, 2010 clearly signaled a determination by IDPH that the immediate jeopardy at Rosewood was not abated until August 13, 2010.

In sum, the ALJ reasonably concluded that corrective measures taken by Rosewood on August 7, 2010 provided insufficient assurance that medication errors like those affecting Resident 2 were not likely to recur. Accordingly, we affirm the ALJ's conclusion that CMS was not clearly erroneous in determining that Rosewood did not abate the immediate jeopardy until August 13, 2010.

2. *Substantial evidence supports the ALJ's conclusion that Rosewood remained noncompliant with 42 C.F.R. § 483.25(m)(2) on August 13, 2010, and that its noncompliance with that requirement continued from August 13 through October 27, 2010.*

Rosewood contends that it was back in substantial compliance with section 483.25(m)(2) – the requirement to keep residents free from significant medication errors – by August 13, 2010. RR at 13. The ALJ disagreed, concluding that Rosewood remained in a state of noncompliance with that regulation, albeit at less than the immediate jeopardy-level of severity, from August 13 through October 27, 2010. ALJ Decision at 4-5, 7-8. In support of that conclusion, the ALJ pointed to the fact that IDPH had found Rosewood noncompliant with section 483.25(m)(2) during the October survey. *Id.* at 7. The SOD for the October survey indicates that Rosewood failed to provide Resident 14 with prescribed cardiac medication (Diltiazem) on October 19, 2010, the date she was

admitted to Rosewood, because its staff failed to obtain that drug from the pharmacy. CMS Ex. 2. The ALJ found that "[t]he noncompliance established by this episode is, but for the level of harm involved, factually indistinguishable from what happened to [Resident 2] on August 6-7" and thus "is compelling evidence of continuing noncompliance" with section 483.25(m)(2). ALJ Decision at 7.

Although Rosewood does not challenge the October survey's noncompliance finding, it disputes the ALJ's finding that it was in continuous noncompliance with section 483.25(m)(2) between August 13, 2010 and the October survey. Rosewood claims that, in the September survey, IDPH actually found Rosewood to be in substantial compliance with section 483.25(m)(2) as of August 13, 2010. RR at 18. It therefore asserts that there was an intervening period – from August 13 through mid-October 2010 (when the medication error involving Resident 14 occurred) – in which it was in substantial compliance with section 483.25(m)(2). *Id.*

We carefully reviewed the SOD for the September survey as well as IDPH's September 7, 2010 letter notifying Rosewood of that survey's findings. *See* CMS Ex. 1; CMS Ex. 3. Nowhere in those documents does IDPH indicate that Rosewood achieved substantial compliance with section 483.25(m)(2) during or prior to the completion of the September survey. As noted in the previous section, the SOD for the September survey indicates only that Rosewood took corrective actions sufficient to reduce the noncompliance with that requirement below the immediate jeopardy-level of severity. *See* CMS Ex. 1, at 14. We agree with the ALJ, for the reasons he gave (*see* ALJ Decision at 8), that Rosewood misconstrued the SOD on this issue.[5]

Even if the SOD had contained a determination that Rosewood was in substantial compliance with section 483.25(m)(2) on August 13, 2010, that fact would not be legally conclusive. ALJ Decision at 8. State survey agencies like IDPH merely recommend findings of substantial compliance or noncompliance; ultimate authority for certifying a SNF as compliant with Medicare requirements rests with CMS. Social Security Act[6]. §§ 1819(h)(l)-(2); 42 C.F.R. §§ 488.11, 488.12, 488.24, and 488.452(a)(2); *Omni Manor Nursing Home*, DAB No. 2431, at 14-15 (2011). Here, CMS did not determine that Rosewood was back in substantial compliance with section 483.25(m)(2) prior to the

[5] Rosewood also fails to account for the fact that the September survey's citation of noncompliance was based, in part, on a medication error involving a second resident, Resident 5. IDPH found, and Rosewood does not dispute, that the medication error involving Resident 5 by itself demonstrated noncompliance with section 483.25(m)(2). There is no finding by IDPH in the SOD (or elsewhere) that Rosewood took sufficient corrective action by August 13, 2010 in response to that error to achieve substantial compliance.

[6] The current version of the Social Security Act can be found at http://www.ssa.gov/OP_Home/ssact/ssact-toc.htm.

October survey. Indeed, CMS expressly notified Rosewood on January 6, 2011 that its noncompliance with section 483.25(m)(2) continued, uninterrupted, from August 13 through October 27, 2010. CMS Ex. 4, at 2. That determination would supersede any conflicting finding by IDPH.

The Board has held that the noncompliance found during a survey is "presumed to continue until the facility demonstrates that it has achieved substantial compliance." *Taos Living Center*, DAB No. 2293, at 20 (2009). To lay the foundation for that demonstration, the SNF first must "promptly file for CMS's approval a plan stating when and how the facility will correct the conditions" that violate Medicare requirements. *Regency Gardens Nursing Center*, DAB No. 1858, at 11 (2002) (citing 42 C.F.R. §§ 488.401 and 488.402(d)). A noncompliant SNF "is not considered to be [back] in substantial compliance until a determination has been made, through a revisit survey or based on 'credible written evidence' that 'CMS or the State can verify without an on-site visit, that the facility returned to substantial compliance.'" *Omni Manor Nursing Home*, DAB No. 2431, at 6 (2011) (citing or quoting 42 C.F.R. § 488.454(a)(1) and *Oceanside Nursing and Rehabilitation Center*, DAB No. 2382, at 20 (2011)). Regulations and prior Board decisions make clear that a SNF's "noncompliance is deemed to be corrected or removed only when the incidents of noncompliance have ceased and the facility has implemented appropriate measures to ensure that similar incidents will not recur." *Florence Park Care Center*, DAB No. 1931, at 30 (2004); *see also Oceanside Nursing and Rehabilitation Center* at 20. Moreover, the SNF "bears the burden of showing that it returned to substantial compliance on a date earlier than that determined by CMS," and the Board "has rejected the idea that CMS must establish a lack of substantial compliance during each day in which a remedy remains in effect." *Owensboro Place and Rehabilitation Center*, DAB No. 2397, at 12 (2011).

Having been found noncompliant with section 483.25(m)(2) during the September survey, Rosewood was required to submit to IDPH a plan of correction (PoC) for that noncompliance. During the ALJ proceeding, Rosewood produced a document that purports to be its PoC for all of the deficiencies found during the September survey. P. Ex. 14. Concerning its noncompliance with section 483.25(m)(2) – which, as noted, involved Resident 5 and Resident 2 – the PoC states that all "direct care staff" would be "inserviced" about the facility's policies concerning the transcription of, and compliance with, medication orders; that "admission orders for all new admits [would] be reviewed to insure accuracy"; and that the DON (or the DON's designee) would "monitor for compliance by reviewing one resident chart per week to insure medication orders are

correctly transcribed and the medications are given as ordered."[7] *Id.* at 1-2. The PoC further indicated that Rosewood intended to implement these and other measures by September 2, 2010. *Id.* at 2.

Rosewood did not submit evidence that it satisfactorily implemented these measures by September 2 (or prove that it provided IDPH such evidence during the October survey). For example, the record contains no documentation verifying that particular employees were inserviced and no testimony from instructors or participants describing the topics covered during inservicing. Hence, it is impossible to verify that "all" direct care staff were adequately inserviced by September 2. In addition, Rosewood failed to submit evidence that "admission orders for all new admits" were "reviewed to insure accuracy" or that the DON performed periodic spot checks of residents' charts, as called for in the PoC. Furthermore, the medication error involving Resident 14, which occurred less than seven weeks after the September survey, supports an inference that the corrective measures in the PoC were either not performed as promised or were inadequate to ensure that newly admitted residents timely received prescribed medication. Rosewood does not point to any evidence dispelling that inference. We thus affirm the ALJ's finding that Rosewood did not return to substantial compliance earlier than the date determined by CMS (that is, earlier than October 28, 2010).

Rosewood makes one additional argument relating to section 483.25(m)(2). Rosewood contends that the medication errors involving Resident 5 and Resident 2 constituted "past noncompliance" with section 483.25(m)(2) during the September survey. To support this argument, Rosewood points to a "Daily Status Meeting" record signed by Surveyor Robin Conley, R.N. and Bart Becker, Rosewood's Administrator. That meeting record states (in the "Topics Discussed" section): "F333 ⇨ (Immediate Jeopardy) past non-compliance August 13, 2010." Rosewood also points to Administrator Becker's affidavit, in which he states:

> I spoke with Robin Conley . . . during a daily status meeting. During that daily status meeting, Robin Conley told me the IJ tag for F333 would be cited as past noncompliance.

[7] Rosewood asserts that the noncompliance affecting Resident 5 – the failure to transfer that resident's insulin orders from the June MAR to the July MAR – was corrected prior to the September survey, *see* RR at 10, but the evidence it cites for this proposition (pages 7, 8, and 32 of CMS Exhibit 11 and Petitioner's Exhibit 11) does not mention any pre-survey corrective action related to that noncompliance. Moreover, Rosewood's PoC does not allege that Rosewood corrected the noncompliance involving Resident 5 prior to the survey.

P. Ex. 4, at 1. Based on this assertion, Rosewood would have us conclude that the noncompliance had been corrected prior to the completion of the September survey and that CMS had no basis to find that Rosewood's noncompliance with that regulation continued during the period between the September survey and the October survey (when a new basis for noncompliance was found).

There is no merit in Rosewood's contention. For reasons we have just explained, there is no basis in the record to conclude that Rosewood was, in fact, in substantial compliance with section 483.25(m)(2) at the time of the September survey. Moreover, the SOD and IDPH's September 7, 2010 notice letter – and not the alleged verbal representation by a surveyor during the survey – are the best evidence of IDPH's official determination about Rosewood's noncompliance. Neither document in any way suggests that Rosewood had come back into substantial compliance with section 483.25(m)(2) prior to the September survey. CMS Exs. 1 and 3. That omission is consistent with IDPH's own records, which indicate that a purpose of the October survey was to verify whether Rosewood had corrected its noncompliance with section 483.25(m)(2). *See* CMS Ex. 14, at 2-3. There would have been no need to conduct a revisit for that purpose if the September survey had found that the noncompliance had already been corrected. In any event, CMS makes the ultimate determination about when a facility has achieved substantial compliance, not the surveyor or state survey agency. *Cf. Omni Manor Nursing Home* at 14-15 (rejecting a SNF's argument, based on alleged oral statements by state agency surveyors, that the SNF returned to substantial compliance earlier than the date determined by CMS); *Owensboro Place and Rehabilitation Center* at 11 (citing authorities which provide that CMS's compliance determinations supersede determinations by the state survey agency).

3. *Substantial evidence supports the ALJ's conclusion that Rosewood was not in substantial compliance with section 483.20(k)(3)(i).*

Section 483.20(k)(3)(i) states, in relevant part, that "services provided or arranged by the facility must . . . [m]eet professional standards of quality[.]" CMS determined that Rosewood was noncompliant with this requirement based on survey findings concerning Resident 1 and Resident 5. CMS Ex. 1, at 1-4.

Rosewood does not dispute (and did not dispute below) that the survey findings regarding **Resident 5's** insulin orders demonstrated noncompliance with section 483.20(k)(3)(i). *See* P.'s Pre-Hearing Br., dated May 12, 2011, at 13; P.'s Motion for Partial Summary Judgment (MPSJ), dated June 29, 2011, at 4-7; P.'s Closing Br., dated Sept. 16, 2011, at 7; RR at 22. In this appeal, Rosewood merely contends that it corrected the noncompliance prior to the September survey, a contention we rejected above. *See infra* footnote 7. This undisputed finding of noncompliance is a sufficient basis for us to uphold the ALJ's conclusion that Rosewood was not in substantial compliance with section 483.20(k)(3)(i).

We also, however, find substantial evidence in the record to support the ALJ's conclusion that Rosewood arranged for services for **Resident 1** that did not meet professional standards of quality. The ALJ relied on the following findings with respect to this resident:

> On July 19, 2010, a gastrostomy feeding tube [or g-tube] was surgically inserted into [Resident 1's] stomach. Difficulties with keeping the tube unblocked were encountered subsequently, while [Resident 1] resided at [Rosewood]. On July 29, 2010, the resident's surgeon ordered that the tube be changed. A nurse practitioner replaced the tube with a smaller diameter tube than had originally been implanted. Furthermore, the tube was not placed properly. On July 31, 2010, [Resident 1] was hospitalized. The resident received emergency surgery to address a dislodged gastrostomy tube and to deal with complications resulting from the improper placement of the tube.

ALJ Decision at 9 (citations omitted).[8] The ALJ stated that these facts "show mismanagement" of Resident 1's care consisting of a "botched effort at replacing the tube, coupled with use of a tube that was smaller than that which had been ordered by the resident's physician." *Id.* at 10.

Rosewood argued before the ALJ that CMS had improperly found noncompliance with section 483.25(k)(3)(i) because Resident 1's g-tube was changed by the nurse practitioner (identified as Z6 in the SOD), an "independent health care professional who was not an employee of the facility." P.'s Closing Br. at 8. The ALJ did not find that Z6 was a facility employee, but said that Rosewood's defense was that Z6 was an independent **contractor**. ALJ Decision at 9. Although the ALJ stated more broadly that a "skilled nursing facility is responsible for everything that happens on its premises," he relied for his noncompliance finding on the wording of section 483.20(k)(3)(i), noting that it expressly applies to services "arranged by" the SNF, "not just to those that are provided by employees." *Id.* at 9-10. "Using [Rosewood's] logic, said the ALJ, "a facility could hire contractors to perform all of its services and escape liability for the contractors' actions on the basis that the contractors and their employees are not employees of the facility." *Id.* at 9.

[8] According to nursing records, the impetus for Resident 1's hospitalization was the nursing staff's discovery on July 31st that liquid and medication put through the feeding tube were coming back out through the tube's insertion site. CMS Ex. 8, at 45.

On appeal, Rosewood does not allege that Z6 was **not** an "independent contractor" with Rosewood (or challenge other language in the ALJ Decision implying that Z6 had a contract with Rosewood to perform g-tube services), nor does Rosewood deny that the g-tube services at issue were "arranged by" Rosewood within the meaning of section 483.20(k)(3)(i). In addition, Rosewood does not point to any evidence that the care its staff and Z6 provided to Resident 1 for her g-tube met professional standards of quality.[9] Instead, Rosewood challenges the ALJ's conclusions on several different grounds.

First, Rosewood contends that the ALJ improperly applied a theory of "strict liability" and that, under the ALJ's reasoning, "the only evidence needed to sustain a violation of professional standards is that there is some harm or potential for harm to the resident." RR at 18-19. We disagree. The ALJ did not, in fact, apply the principle of strict liability to support his determination of noncompliance. To the contrary, the ALJ found noncompliance because Rosewood had conceded that the services it provided to Resident 5 did not meet professional standards of quality and did not show that the services it arranged for Resident 1 met such standards and because Rosewood's failures to comply with section 483.20(k)(3)(i) had the potential for more than minimal harm. "The Board has made clear that a strict liability standard is not being applied simply because a facility is held to 'standards enunciated in the relevant participation requirement and its own policies[.]'" *Beverly Health Care Lumberton*, Ruling No. 2008-5 (Appellate Division), at 6 (quoting *Tri-County Extended Care Center*, DAB No. 2060, at 5 (2007) and citing other Board decisions).

In a related vein, Rosewood suggests that it is being improperly sanctioned for the negligent conduct of other, independent actors. Reiterating that Z6 was not its "employee," Rosewood asserts that it had "no control or authority over" Z6, and that a "review of the facts surrounding the replacement of [Resident 1's] G tube shows that it was [Z6], operating in accordance with her authority under the [Illinois] Nurse Practice Act, who made the decision to replace [Resident 1's] G-tube" and to use one that was smaller than the original. RR at 19, 21. Even assuming the Illinois law is relevant here, the record does not establish that, **in replacing Resident 1's g-tube**, Z6 was, in fact, operating under any independent authority she may have had under that law. The record indicates instead that Z6 replaced the g-tube in her role of providing advice and assistance on g-tube care to Rosewood, as CMS inferred from nurse's notes regarding Z6's interactions with Rosewood's staff. *See* CMS Response Br. at 20-22; CMS's Response to P.'s MPSJ (dated July 28, 2011) at 10-12.

[9] Rosewood does challenge the ALJ's implicit finding that the replacement tube was not the size ordered by the resident's surgeon. Rosewood argues that the surgeon's statement regarding this issue was hearsay and was contradicted by the sworn affidavit of the staff nurse who called the surgeon. RR at 21. Contrary to what Rosewood suggests, a hearsay statement can constitute substantial evidence to support an ALJ's finding, where the statement has sufficient indicia of reliability, such as where a party had an opportunity to subpoena the declarant (as Rosewood did) but did not do so. 42 C.F.R. § 498.61; *Richardson v. Perales*, 402 U.S. 389, 402 (1971).

Rosewood did submit an affidavit from its administrator attesting that Z6 was not a facility employee, that Z6 "works for" Resident 1's attending physician, and that Z6 used "independent judgment in the care of the resident and gives orders and prescribes treatment for the resident." P. Ex. 4, at 1. This affidavit does not, however, directly address the issue of whether Z6 furnished the particular services at issue here under an arrangement with Rosewood or in some other capacity. Nor does it establish that the services were billed either by Z6 or by Resident 1's attending physician, rather than being considered part of the g-tube services Rosewood was obliged to provide and for which it was paid. Thus, the affidavit is not inconsistent with the ALJ's conclusion that the services at issue were services "arranged by" Rosewood. *See* Act § 1861(w) (providing that an "arrangement" relates to a service for which a SNF receives payment and for which the patient is entitled to have Medicare payment made on his or her behalf); 63 Fed. Reg. 26,252, 26,300, 26,302 (May 12, 1998) (discussing provisions that make a SNF responsible for services by outside resources under "arrangement"). By contrast, there is evidence that Rosewood represented to Resident 1's surgeon that it was capable of changing the g-tube and that Rosewood had asked Z6 to "assist" it in doing so. CMS Ex. 7, at 21 (notes of survey interview of Resident 1's surgeon, who reportedly obtained Rosewood's assurance that it could perform the procedure); CMS Ex. 8, at 11 (report authored by Z6 stating that "[s]taff requests assist with PEG tube replacement"); *see also* CMS Ex. 8, at 6 (staff nurse's note to call the surgeon to see if "we" can change the tube).[10]

In addition, Rosewood does not dispute that the arranged-for service failed to meet professional standards of quality. Rosewood merely asserts, without evidentiary support, that it had "no affiliation" with Z6 and "no control" over her. P.'s Closing Br. at 8; *see also* P.'s Pre-Hearing Br. at 10-13; P.'s MPSJ at 6-7. However, section 483.20(k)(3)(i) and other regulations clearly impose on a SNF the responsibility to ensure the quality of services provided or arranged by it. *Agape Rehabilitation of Rock Hill*, DAB No. 2411, at 9 (2011) (holding an SNF responsible for the services provided to its residents by contractors, as well as staff, is consistent not only with the plain language of section 483.20(k)(3)(i), but with the quality of care requirements in section 483.25). In other words, the regulations do not distinguish "between services which a facility provides directly and those for which it arranges in order to carry out the resident's plan of care." *Fort Madison Health Center*, DAB No. 2403, at 9 (2011).

Rosewood asserts that "as a policy," Rosewood "does not replace G-tubes and relies on the resident's doctor or nurse practitioner to insert the correct replacement tube using their independent professional judgment." RR at 21-22. We see no contemporaneous documentation of that policy, and no evidence that the policy, if it existed, was even in

[10] The nurse who called the surgeon stated in an affidavit that she did not tell the surgeon that the facility would change R1's g-tube. P. Ex. 9. Rosewood submitted no evidence, however, directly contradicting Z6's contemporaneous written report that she was asked to assist Rosewood staff in replacing the tube.

place on July 29, 2010, the date that Z6 replaced Resident 1's g-tube, much less that Rosewood was following that policy with respect to Resident 1's g-tube. Nor did Rosewood present any evidence that g-tube replacement could never be considered part of the appropriate treatment and services for a g-tube that a facility is obligated to provide under section 483.25(g).

Rosewood also contends that it reasonably relied on Z6's apparent expertise. RR at 24-25. Rosewood says that Z6 was a licensed "advanced practice nurse" (APN) under the Illinois Nurse Practice Act (INPA) and asserts that replacement of Resident 1's g-tube was within an APN's scope of practice under the IPNA. RR at 19; P. Ex. 6. The fact that Z6 may have been licensed as an APN, however, does not mean that Rosewood cannot be held responsible for services Z6 provided under arrangement with Rosewood, irrespective of any expertise she may have had. Federal law, not state law, governs noncompliance determinations. *Lakeridge Villa Healthcare Center*, DAB No. 2396, at 13 (2011). Moreover, in referring to the "scope of practice" of an APN under the INPA, Rosewood omits to mention that when an APN "engages in clinical practice **outside of a hospital or ambulatory surgical treatment center** in which he or she is authorized to practice, the [APN] must have a written collaborative agreement" that describes the APN's working relationship with a "collaborating physician" and which "authorize[s] the categories of care, treatment, or procedures to be performed by the [APN]." *Id.* § 65-35(a), (a-5), and (b) (emphasis added). Thus, under the INPA, any services Z6 provided in Rosewood as an APN needed to be provided in accordance with a collaborative agreement. While the administrator's affidavit states that Z6 works for Resident 1's attending physician, Rosewood did not establish that, in replacing Resident 1's g-tube, Z6 was acting under a written collaborative agreement with the physician, rather than under an arrangement with Rosewood to assist it with resident care.

For all of the reasons above, we affirm the ALJ's conclusion that Rosewood was not in substantial compliance with section 483.20(k)(3)(i).

4. *Substantial evidence supports the ALJ's conclusion that Rosewood was not in substantial compliance with 42 C.F.R. § 483.25(g)(2).*

Section 483.25(g)(2) requires a SNF to "ensure" that a "resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills." The regulation's intent is to ensure that a SNF takes appropriate measures to minimize or resolve

complications associated with tube feeding and provides services to restore a resident's normal eating function. SOM, Appendix PP (guidelines for F322).[11] Such measures include verifying that a feeding tube is "properly placed." *Id.*

The ALJ based his conclusion that Rosewood was noncompliant with section 483.25(g)(2) on evidence concerning two residents: Resident 1 and Resident 4. As discussed, the ALJ found, and Rosewood does not dispute, that **Resident 1** received an improperly placed g-tube on July 29, 2010 and was hospitalized as a result. Those facts are sufficient to demonstrate noncompliance with section 483.25(g)(2) absent a showing by Rosewood – one it did not make – that its nursing staff took adequate measures to prevent or detect the improper placement and that the adverse outcome was unavoidable. *Cf. Evergreene Nursing Care Center*, DAB No. 2069, at 7 (2007) (holding that a SNF has the ultimate burden of demonstrating substantial compliance with Medicare requirements once CMS makes a prima facie showing of noncompliance); *Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004) (discussing the parties' evidentiary burdens before the ALJ), *aff'd*, *Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 F. App'x 181 (6th Cir. 2005).

The ALJ's conclusion is buttressed by evidence that Rosewood provided Z6, the nurse practitioner, with a replacement g-tube that was not the same size as the original. The original tube was inserted by Resident 1's surgeon on July 19, 2010. CMS Ex. 1, at 5. It was 22 French units in diameter with a 10 millimeter balloon. *Id.*; *see also* CMS Ex. 8, at 10. On July 29, 2010, Rosewood provided Z6, and Z6 inserted, a replacement tube that was 20 French units in diameter with a 20 millimeter balloon. CMS Ex. 8, at 11; CMS Ex. 1, at 6. In short, the replacement tube was smaller in diameter and had a larger balloon than the original. CMS Ex. 1, at 6. In a survey interview, the surgeon reportedly stated that he had instructed Rosewood to replace the g-tube with one of the same size. CMS Ex. 7, at 21. Rosewood submitted an affidavit from a nurse who stated that she was the Rosewood employee to whom the surgeon spoke about Resident 1's feeding tube. P. Ex. 90. In her affidavit, the nurse denied having "discussions with [the surgeon] regarding the size or type of G tube replacement . . . ." *Id.* at 1.

We note that Rosewood did not subpoena the surgeon to testify regarding what, if anything, he told the nurse about the size of the feeding tube although Rosewood had the opportunity to do so. Even if we accepted the nurse's statement as true, however, Rosewood could still reasonably be faulted for not exercising adequate diligence to ensure that Resident 1 received appropriate treatment and services for her g-tube. If Rosewood's nurse had no instructions from Resident 1's surgeon regarding the proper size of tube to use, she should not have provided a replacement g-tube to Z6 without consulting with the surgeon about that issue or ensuring that Z6 had consulted with him.

[11] Appendix PP is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads//som107ap_pp_guidelines_ltcf.pdf.

Rosewood did not allege, or provide any evidence, that its nurse exercised reasonable nursing judgment in providing a replacement tube of a different size, without having any assurance that the tube, once inserted, would function effectively and not cause medical complications. For these reasons, we affirm the ALJ's conclusion that Rosewood was noncompliant with section 483.25(g)(2) in caring for Resident 1.

Rosewood suggests that it met its regulatory obligation with respect to Resident 1 by relying on the apparent expertise of Z6. RR at 24-25. As we have discussed, Rosewood produced inadequate evidence that its reliance on Z6 was reasonable. It also failed to show that its nursing staff had no obligation to verify whether Z6 had correctly inserted Resident 1's g-tube or that the procedure's adverse outcome was beyond its ability to foresee or prevent. Rosewood's nursing notes indicate that verifying placement of a g-tube was among the nursing services that Rosewood undertook to provide to Resident 1. CMS Ex. 8, at 5 (entry for July 27, 2010) and 7 (entry for July 30, 2010).

The evidence concerning **Resident 4** also supports the ALJ's conclusion that Rosewood was noncompliant with section 483.25(g)(2). The ALJ found the following facts concerning Resident 4, who was admitted to Rosewood on July 5, 2010 following cranial surgery and placement of a jejunostomy tube (another type of feeding tube):

> . . . [T]he evidence establishes that, on July 6, 2010, Petitioner's staff discovered that the resident had a clogged feeding tube. The resident needed hospitalization to address the problem. At the hospital, it was determined that the resident's feeding tube was dislodged due to feeding tube mismanagement.

ALJ Decision at 10 (citations omitted). The determination of "feeding tube mismanagement" is contained in a report written by the hospital physician who treated Resident 4. CMS Ex. 10, at 37-38.

The ALJ inferred from the hospital physician's report that Resident 4's feeding tube became dislodged at Rosewood. That inference was reasonable given that it was based on the first-hand impression of an examining physician and given the absence of any evidence that Resident 4 arrived at Rosewood with a dislodged feeding tube. We agree with the ALJ, moreover, that the hospital physician's impression that dislodgment was a consequence of "mismanagement" at Rosewood is prima facie evidence of noncompliance with section 483.25(g)(2). Rosewood thus had the burden to demonstrate that it took adequate steps to maintain proper placement of Resident 4's feeding tube prior to her hospitalization but failed to meet that burden. Rosewood did not offer any evidence of procedures it followed to monitor tube placement or reduce the likelihood of accidental displacement. Nor did Rosewood present evidence that dislodgment was likely the result of equipment malfunction or other factors beyond its ability to prevent or control.

Rosewood complains that the hospital physician's determination of g-tube "mismanagement" was "hearsay," RR at 23, but, as we indicated earlier, hearsay is admissible in this administrative proceeding. Moreover, Rosewood neither objected to CMS's introduction of that evidence in the proceeding before the ALJ nor demonstrated in this appeal that the evidence lacks sufficient indicia of reliability.

Rosewood complains that the surveyors did not interview Resident 4's primary care physicians and ask them whether they thought that the nursing staff had mismanaged Resident 4's feeding tube. RR at 23. However, the conduct of the survey is not at issue in this proceeding. The issue before the ALJ (and the Board) is the validity of CMS's determination of noncompliance, and a resolution of that issue "hangs on the ALJ's de novo review of the evidence" submitted by the parties in support of, or opposition to, that determination. *Northlake Nursing and Rehabilitation Center*, DAB No. 2376, at 10 (2011). Moreover, Rosewood was not deprived of any opportunity to obtain (by subpoena or other means) statements or testimony from Resident 4's physicians concerning the quality of care provided to Resident 4.

For these reasons, we affirm the ALJ's conclusion that Rosewood was not in substantial compliance with section 483.25(g)(2) in caring for Resident 1 and Resident 4.

5. *CMS lawfully imposed a $3,050 per-day CMP from August 6 through August 12, 2010.*

The $3,050 per-day CMP imposed by CMS for the immediate jeopardy-level noncompliance is the minimum amount for noncompliance at that level. Rosewood contends, however, that this CMP should have accrued for only one day (August 6, 2010) instead of seven. The basis for that contention is Rosewood's claim that it abated the immediate jeopardy on August 7, 2010. However, as we discussed above (in section one), Rosewood has not shown that CMS's determination that the immediate jeopardy was not abated until August 13, 2010 was clearly erroneous. CMS therefore lawfully imposed a $3,050 per-day CMP from August 6 through August 12, 2010.

6. *CMS lawfully imposed a $200 per-day CMP from August 13 through October 27, 2010.*

Rosewood does not dispute the reasonableness of the amount of the $200 per-day CMP but contends that this CMP should have stopped accruing on September 3, 2010 because it was in substantial compliance with section 483.25(m)(2) by August 13, 2010 and with all other requirements by September 3, 2010. RR at 26-28. However, we have affirmed the ALJ's conclusion that Rosewood was not in substantial compliance with section 483.25(m)(2) from August 13, 2010 through October 27, 2010. Accordingly, we hold that CMS lawfully imposed a $200 per-day CMP from August 13 through October 27, 2010.

7. *CMS lawfully imposed a DPNA from September 27 through October 27, 2010.*

For the same reasons that it challenges the accrual of the $200 per-day CMP beyond September 2, 2010, Rosewood contends that the DPNA should not have taken effect on September 27, 2010 or continued through October 27, 2010. RR at 28. This contention lacks merit. The regulations authorize CMS to impose a DPNA for any days on which a SNF is not in substantial compliance. *See* 42 C.F.R. § 488.417(a). Because Rosewood was not in substantial compliance with section 483.25(m)(2) from September 27 through October 27, 2010, CMS lawfully imposed a DPNA for that period.

Conclusion

For the reasons outlined above, we affirm the ALJ Decision.

/s/
Sheila Ann Hegy

/s/
Leslie A. Sussan

/s/
Judith A. Ballard
Presiding Board Member